Federal Centers for Medicaid and Medicaid Services (CMS) for Home and Community-Based Services Waivers - Required Assurances Related to the Support and Service Coordination

CMS Requirements for Home and Community-Based Services Waivers
Assure that each person approved for the waiver meets a Level of Care. The Level of Care is reevaluated at least annually. Qualified state professionals establish level of Care.
Complete an individual assessment and develop a comprehensive individual written plan of care. Federal Financial Participation (FFP) funds will not be claimed for waiver services furnished prior to the development of the plan of care.
Assure that all services are delivered per the approved written plan of care. FFP will not be claimed for waiver services, which are not included in the individual written plan of care.
The plan of care will be subject to the approval of the Medicaid agency.
The Medicaid agency provides the following assurances to CMS that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver.
Assure that all service providers are qualified.
The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.
Fiscal Management Criteria: • Assure that average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted. • Assure that actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not exceed 100 percent of the amount that would be incurred in institutional setting(s) in the absence of the waiver. • Provide CMS annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by CMS. • Assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver.
The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality.
The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver. Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.